STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: North Carolina

A. The following charges are imposed on the medically needy for services:

Service	Type Charge Deduct.	Coins.	Copay	Amount and Basis for Determination
Podiatrist			X	$1.00 per visit; based on the State's average payment of $20.87 per visit
Outpatient			X	$3.00 per outpatient visit; based on the State's average payment of $109.55 per outpatient visit
Physicians			X	$3.00 per visit; based on the State's average payment of $50.22 per visit
Legend drugs & insulin			X	$1.00 per prescription; based on the State's average payment of $22.19 per prescription
Dental			X	$3.00 per visit; based on the State's average payment of $75.86 per visit
Chiropractic			X	$1.00 per visit; based on the State's average payment of $20.41 per visit
Optical supplies and services			X	$2.00 per visit; based on the State's average payment of $33.74 per visit
Optometrists			X	$2.00 per visit; based on the State's average payment of $33.23 per visit

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B. The method used to collect cost sharing charges for medically needy individuals:

/X/ Providers are responsible for collecting the cost sharing charges from individuals.

/ / The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Federal limits on the services for which co-payment applies and State limits on the number of covered physicians' services and prescription drugs restricts the maximum co-payment charges. The State's scope of services is broad and eligible recipients have relatively low, if any, out-of-pocket medical expenses; therefore, all recipients subject to co-payment are able to pay the minimal charges. Should a recipient claim to be unable to pay the required co-payment, the provider may not deny him service, but may arrange for the recipient to pay the co-payment at a later date.

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers must bill total charges on the claim form. The claims processing system deducts the appropriate amount of co-payment. Services excluded from co-payment are:

ICF, SNF, ICF-MR
Home Health
Rural Health
Hearing Aid
Ambulance
EPSDT
Family Planning
Home Community-Based Alternatives Program services
Services covered by both Medicare and Medicaid
Other diagnostic, screening, preventive and rehabilitative services
Non-hospital Dialysis
State-owned mental hospitals
Services to children under age 21
Services related to pregnancy
Hospital inpatient and emergency room
HMO and Prepaid Plan

E. Cumulative maximums on charges:

/X/ State policy does not provide for cumulative maximums.

/ / Cumulative maximums have been established as described below: